

CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIAMI</u>			
c. LENGTH OF STAY IN 1b <u>3 months</u>				d. STREET ADDRESS <u>276 NW 6th St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>13th & Boardwalk</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>(None)</u> Last <u>Askew</u>				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Approx 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beliman Hotel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington County Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Archie Askew</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>262-05220</u>			
17. INFORMANT <u>Robert Archie Adams</u>				Address <u>1702 Calhoun St Jacksonville Florida</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio-sclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 8</u> , 19 <u>56</u> , to <u>Aug 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>56</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u> DATE SIGNED <u>Aug 25, 56</u>			
PHYSICIAN'S NAME (Type) <u>F. J. Townsend Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Denville Washington Co. Ga</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>AUG 30 1956</u> DATE			
				24b. REGISTRAR'S SIGNATURE <u>Helen E. Hayward</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 3

AUG 30 1956

RECEIVED

8843

CERTIFICATE OF DEATH

Reg. Dist. No.

68831

356

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route #2				d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) Jeffery Andrew Bratten				4. DATE OF DEATH Month 8 Day 19 Year 19 56			
5. SEX Male	6. COLOR OR RACE A.A.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 15 56		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) USA Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Bratten				14. MOTHER'S MAIDEN NAME Ethel Purnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William H. Bratten, Berlin, Md. Rt # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/15 , 19 56 , to 8/19 , 19 56 , that I last saw the deceased alive on 8/18 , 19 56 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Loory U. Shely				ADDRESS (Street, city or town, state) Berlin Md			
PHYSICIAN'S NAME (Type) Loory U. Shely				DATE SIGNED 8/21/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-20-56		22c. NAME OF CEMETERY OR CREMATORY Davis Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md Rt #2	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md				24a. REC'D BY REGISTRAR AUG 22 1956		24b. REGISTRAR'S SIGNATURE John F. Stewart	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11247

Form with multiple lines for text entry, including fields for name, age, sex, date of death, and cause of death. The text is mostly illegible due to fading.

BUREAU V. I.

AUG 22 1956

RECEIVED

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

DATE

[Faint, mostly illegible handwritten text in the main body of the certificate, likely containing details of the deceased and the cause of death.]

BUREAU V. B.

MAY 13 1956

RECEIVED

8845

CERTIFICATE OF DEATH

188833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
c. LENGTH OF STAY IN <u>94 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Parker</u> Last <u>Cherish</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13 - 1861</u>
9. AGE (In years last birthday) <u>94 1/2</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>17</u> Hours <u>24</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockton, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>David Cherish</u>		14. MOTHER'S MAIDEN NAME <u>Rennie, Duber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. John E. Cherish</u>		Address <u>Stockton, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>490.X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>490.X</u> DUE TO (c) <u>490.X</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 4</u> , 19 <u>56</u> , to <u>Aug. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 8</u> , 19 <u>56</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones, M.D.</u>		DATE SIGNED <u>8/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Aug 12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Stockton, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Jones, Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 13 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Thayer Cooper</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14

BUREAU V. B.

AUG 13 1956

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8845 **CERTIFICATE OF DEATH**

08834

Reg. Dist. No. 351

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Worcester</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Worcester</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Snow Hill Road #1</i>	LENGTH OF STAY (in this place) <i>68 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Snow Hill Road #1</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>George</i> (First) <i>W.</i> (Middle) <i>Dale</i> (Last)		4. DATE OF DEATH (Month) <i>Aug.</i> (Day) <i>29</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 10/1887</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>68 1/4</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, md</i>
13. FATHER'S NAME <i>Harry Dale</i>		14. MOTHER'S MAIDEN NAME <i>Amy Bowyer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or last) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS <i>Miss Sattin Dale, Snow Hill, md</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE (A) <i>Congestive Heart Failure</i>		2.	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County)	
(State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/22, 1956, to 8/29, 1956, that I last saw the deceased alive on 8/28, 1956, and that death occurred at 1:00 PM, from the causes and on the date stated above.			
SIGNATURE <i>Thomas L. Jones, MD</i>		DATE SIGNED <i>8/30/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24. ADDRESS (Street, city, town, state) <i>Snow Hill, md</i>	
DATE THEREOF <i>Sept. 1/36</i>		NAME OF CEMETERY OR CREMATORY <i>West View</i>	
LOCATION (City, town, or county) <i>Snow Hill, md</i>		(State) <i>md</i>	
25. REGISTRAR'S SIGNATURE <i>Clayton Cooper</i>		26. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Cooper</i>	
27. ADDRESS <i>Snow Hill, md</i>			

CERTIFICATE OF DEATH

THE DEPARTMENT OF HEALTH - ALABAMA

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

RECEIVED

BUREAU V. 4

AUG 31 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8847

CERTIFICATE OF DEATH

08835

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle A. Last DALE				4. DATE OF DEATH Month Aug. Day 12 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan, 1 1888		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Dale				14. MOTHER'S MAIDEN NAME K1 tty Whaley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X (If yes, give war or date of service) X		16. SOCIAL SECURITY NO. X		17. INFORMANT Hayward Dale Address Whaleyville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chr Myocardium - acute 542X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr Hypertension DUE TO (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 1/4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11:00 , 19 56 , to Aug 12 , 19 56 , that I last saw the deceased alive on Aug 11 , 19 56 , and that death occurred at 6:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles R. Davis M.D.				ADDRESS (Street, city or town, state) Baltimore 714 DATE SIGNED 8-13-56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Pullets Chapel		22d. LOCATION (City, town, or county) (State) Whaleyville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley ADDRESS Whaleyville Md 24a. REC'D BY REGISTRAR Aug 17 1956 24b. REGISTRAR'S SIGNATURE John F. Hayward							

RECEIVED
AUG 17 1907
BUREAU V. S.

3848

CERTIFICATE OF DEATH

08836
Reg. Dist. No. 357

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL		c. LENGTH OF STAY IN 1b SNOW HILL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		d. STREET ADDRESS 411 Tingle St.	
3. NAME OF DECEASED (Type or print) First LAURA Middle GINN Last GINN		4. DATE OF DEATH Month AUG. Day 15 Year 1956	
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWORK	9. AGE (In years last birthday) 78 yrs
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Riley GINN		14. MOTHER'S MAIDEN NAME SARAH SELBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT Horace Ginn		Address 411 Tingle St. Snow Hill, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive Cardio-vascular DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerotic disease DUE TO (c) 5 yr			INTERVAL BETWEEN ONSET AND DEATH 5 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1954 , 19____, to 8/15/56 , 19____, that I last saw the deceased alive on 8/14/56 , 19____, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Cohen		ADDRESS (Street, city or town, state) Snow Hill, Md.	
PHYSICIAN'S NAME (Type) DR. PAUL COHEN		DATE SIGNED 8/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	8-19-56	Georgetown	Pocomoke Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton		ADDRESS New Church, Va.	24a. REC'D BY REGISTRAR DATE Aug 15, 56
		24b. REGISTRAR'S SIGNATURE Edgar Wharton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88837
 Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 113</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Thomas</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pavo (Rural)</u> d. STREET ADDRESS <u>Rural</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>A. Graham</u> Middle <u>H.</u> Last 4. DATE OF DEATH <u>Aug 27</u> Month <u>27</u> Day <u>19</u> Year <u>56</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1906</u> 9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> 11. BIRTHPLACE (State or foreign country) <u>Dalston Georgia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Dan Graham</u> 14. MOTHER'S MAIDEN NAME <u>Mrs. Danton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>James Graham Pavo Georgia</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation with Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend Jr.</u> EXAMINER'S NAME (Type) <u>F. J. TOWNSEND JR.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>8-30-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Houston Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Salisbury, Wicomico Co. Md.</u>		DATE SIGNED <u>Aug 27, 56.</u> 24a. REC'D BY REGISTRAR <u>AUG 31 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u> ADDRESS			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

AUG 31 1956

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Mem 1 Film 202 6-52-56 et

Reg. Dist. No.

188838

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Hotel</u>		d. STREET ADDRESS <u>66 Adams St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS FRANCIS HEALY</u>		4. DATE OF DEATH Month Day Year <u>August 23 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 31, 1912</u>
9. AGE (in years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HEALY</u>		14. MOTHER'S MAIDEN NAME <u>HELEN FERRER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MRS. ELIZABETH LEFFSON</u>		Address <u>6505 44th Ave N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Coronary Thrombosis</u> (c) <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs</u> <u>6-8 days</u> <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kypho-scoliosis sec to Poliomyelitis in childhood</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Herman A. Robbins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HERMAN A. Robbins M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>8/23/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Busby</u>		ADDRESS <u>Busby and</u>	
24a. REC'D BY REGISTRAR <u>Aug 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Hayward</u>	

RECEIVED

AUG 24 1956

BUREAU V. S.

8851

CERTIFICATE OF DEATH

08839

Reg. Dist. No. 355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>ST. MARTINS (RURAL)</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIDA</u> <u>CORDELIA</u> <u>HOLLAND</u>		4. DATE OF DEATH Month Day Year <u>Aug</u> <u>1</u> <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 18, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN V. DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>HETTY CATHERINE TIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. BESSIE HOLLAND, BERLIN, MD</u>		Address <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> DUE TO <u>myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u> <u>19</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>None</u>	
20e. (City or town) <u>None</u>		20f. (County) (State)	
21. I certify that I attended the deceased from <u>July 15, 1956</u> to <u>Aug 1, 1956</u> , that I last saw the deceased alive on <u>July 30, 1956</u> , and that death occurred on <u>Aug 1, 1956</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford E. Schott</u> M.D.		DATE SIGNED <u>Berlin Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT MD BERLIN MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/4/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burboys, Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE 8/5/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Stelen F. Hayward</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:

COUNTY Worcester MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Berlin
 LENGTH OF STAY (In this place) 3 WEEKS
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE PA COUNTY LANCASTER
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN ROCKRESTOWN PA.
 STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

EUGENE KANG HORST

4. DATE OF DEATH

(Month)

(Day)

(Year)

19

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

If UNDER 1 YEAR

If UNDER 24 HRS.

MWMARRIEDOCT. 2, 193223 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

WILLIAM K. HORST
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

YESMRS. E. K. HORST, 2140 Rockrestown Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

105 min.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Building site

21c. (City or town)

(County)

(State)

BerlinWorcester CoMD21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Aug 1 1956 3:42 P.M.21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR?

Fell & suffocated

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Herbert G. Radwin M.D.

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED

8/1/56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL8/4/56QuarryvillePA.PA.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/2/56Helen F. HaywardDr. R. D. Burby, Berlin Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please use the spaces of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8853

CERTIFICATE OF DEATH

1888411
Reg. Dist. No. 357

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>				d. STREET ADDRESS <u>Stockton, Md.</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL MASON</u>				4. DATE OF DEATH Month Day Year <u>August 13 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COI.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN MASON</u>				14. MOTHER'S MAIDEN NAME <u>Ester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Philmore Mason - Stockton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Cerebral Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 7</u> , 19 <u>86</u> , to <u>Aug. 13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 12</u> , 19 <u>56</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>325 Mulberry St. Annapolis, Md.</u>			
DATE SIGNED <u>8/13/56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>1st. HOPE</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				ADDRESS <u>DATE Aug 16, 56</u>		24b. REGISTRAR'S SIGNATURE <u>August C. Cooper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 21 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **88841-355**

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Dade	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Ocean City		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ELM St & DRA Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First RICHARD Middle MELVIN Last		4. DATE OF DEATH Aug Month 1 Day 1956 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24 1929 yrs. 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORT	
11. BIRTHPLACE (State or foreign country) Chincoteague, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CARPENTER MELVIN		14. MOTHER'S MAIDEN NAME LUCY FLORENCE COONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES AIR FORCE 1945-1954		16. SOCIAL SECURITY NO. 181 22 3712	
17. INFORMANT Paul Melvin Address Ocean City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH INSTANT			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. PLAYING RUSSIAN ROULETTE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY 1240 Hour July 31 Month 1956 Year	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STORE	20f. (City or town) Ocean City (County) Wor (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE F J Townsend Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) F J TOWNSEND JR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/6/1956	22c. NAME OF CEMETERY OR CREMATORY SILVER BROOKE CREM
		22d. LOCATION (City, town, or county) WILMINGTON	(State) DEL.
23. FUNERAL DIRECTOR'S SIGNATURE Russ A. Burbage		ADDRESS Berlin Md	
24a. REC'D BY REGISTRAR 8/5/56		24b. REGISTRAR'S SIGNATURE Helen F Hayward	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. M.

1956 2 5

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18842

Reg. Dist. No. 255

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Berlin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Point (Bay)		d. STREET ADDRESS C/o Postmaster	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLOYD Middle NORMAN Last POWELL		4. DATE OF DEATH Month Aug. Day 23 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1926
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 56 Min.	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) Hebron, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME James W. Powell		14. MOTHER'S MAIDEN NAME Virgie Mae Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 218-20-7830	
17. INFORMANT Mr. James W. Powell (Father)		Address Parsonsbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suffocation due to drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Herman C. Robbins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Herman C. Robbins		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 26, 1956	22c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR 8/28/56	
ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24b. REGISTRAR'S SIGNATURE John Hayward	

BUREAU N. S.

AUG 28 1956

RECORDED

8840

CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased 1 ved. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peacock Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HERBERT SMITH, Jr.		4. DATE OF DEATH Month Day Year August 19, 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1897
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Appliances	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Smith, Sr.		14. MOTHER'S MAIDEN NAME Marie E. Drew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-1333	
17. INFORMANT Address Florence E. Smith, Pocomoke, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 30 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 1, 19 56, to AUGUST 19, 19 56, that I last saw the deceased alive on AUGUST 19, 19 56, and that death occurred at 8:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Stanford Hamilton M.D.		ADDRESS (Street, city or town, state) Pocomoke City MD	
PHYSICIAN'S NAME (Type) C. Stanford Hamilton		DATE SIGNED 8-20-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/56	
22c. NAME OF CEMETERY OR CREMATORY Presbyterian		22d. LOCATION (City, town, or county) (State) Pocomoke, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson Pocomoke, Md.		24. REC'D BY REGISTRAR DATE 22 1956	
24b. REGISTRAR'S SIGNATURE Rose White			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N. E.

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1956

CERTIFICATE OF DEATH

Reg. Dist. No.

68844
353

8856

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>LIBERTYTOWN</u>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>TRIMBLE</u> Last <u>TRIMBLE</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>	9. AGE (In years last birthday) <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BARBOUR Co. W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN TRIMBLE</u>		14. MOTHER'S MAIDEN NAME <u>EUDORA McCoy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>		16. SOCIAL SECURITY NO. <u>2-4-1-1-5</u> 17. INFORMANT Address <u>MRS. LAURA TRIMBLE BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial attack</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary cald.</u> DUE TO (c) <u>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-4-1956</u> to <u>8-7-1956</u> , that I last saw the deceased alive on <u>8-7-1956</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elias R. Law</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>8-9-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/10/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dona R. Bursage, Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>8-10-56</u>	24b. REGISTRAR'S SIGNATURE <u>Helen S. Hayward</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ROBERT W. R.

1956

112

RECEIVED

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8857

CERTIFICATE OF DEATH

68845

Reg. Dist. No. 357

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill, Md.</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural give location) <u>407 Corington Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Henrietta G. Waters</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 7 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 24 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>201-07-1935</u>		17. INFORMANT & ADDRESS <u>Edwin Allen</u> <u>407 Corington St. Snow Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma of uterus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-yr</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1956</u> to <u>Aug 7, 1956</u> , that I last saw the deceased alive on <u>July 1, 1956</u> and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edwin Allen</u>		M.D. <u>Snow Hill</u>		ADDRESS (Street, city, town, state) <u>Md 8/9/56</u>		DATE SIGNED <u>8/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Tingley Chapel Cem.</u>		LOCATION (City, town, or county) <u>Pocomoke City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Aug 9, 1956</u>		REGISTRAR'S SIGNATURE <u>Edwin E. Cooper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Cooper</u> ADDRESS <u>New Church, Va.</u>			

BUREAU V. B.

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RECEIVED

1956-1-3

8841

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>43 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>402 Laurel Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>H.</u> Last <u>Wessells</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1867</u>	
9. AGE (in years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Wessells</u>				14. MOTHER'S MAIDEN NAME <u>Laura Fenton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Purla Anna Wessells, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis multiple</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis, generalized</u> DUE TO (c) <u>Aging process</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Saw. days.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio, med to head.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>20 July</u> , 19 <u>50</u> , to <u>August 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 August 19 56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Pocomoke, Md.</u>			
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius, Jr.</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Goodwill M.E. Cemetery Rural- Pocomoke, Maryland</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/28/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Anne White</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

AUG 28 1956

RECEIVED

20 July 56

CERTIFICATE OF DEATH

Reg. Dist. No.

188847

355

8858

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>80 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RURAL</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN WILMER JACKSON WHITTINGTON</u>				4. DATE OF DEATH <u>Aug. 19, 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 29, 1875</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
			Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RET)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD (RFD)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN R. WHITTINGTON</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA EMILY PARSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>MRS. J.W. WHITTINGTON</u> Address <u>BERLIN, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr Nephritis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 1 - 1956</u> to <u>Aug 19, 1956</u> that I last saw the deceased alive on <u>Aug 19, 1956</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>8-20-56</u>							
ACTUAL SIGNATURE <u>Chas R. Law</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burby</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>Aug 24 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Kelen F. Hayward</u>	

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CERTIFICATE OF DEATH

BUREAU V. S.

AUG 24 1956

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